

Attachment 4.19A(1)

State Plan Under Title XIX of the Social Security Act  
State: Massachusetts  
Institutional Reimbursement

2. Specialty Hospitals and Pediatric Units

The standard inpatient payment amount per discharge for specialty hospitals and pediatric units (as defined in Section II) shall be equal to the sum of:

97% of the hospital's estimated actual FY90 cost per discharge, adjusted for casemix and inflation; and the hospital-specific pass-through amounts per discharge, direct medical education amount per discharge and the capital amount per discharge.

Derivation of estimated actual FY90 Medicaid costs is described in Section IV.A.2.

Adjustments were made for casemix by dividing the FY90 cost per discharge by the hospital's FY90 casemix index and then multiplying the result by the hospital's casemix index.

Adjustments were made for inflation by multiplying the casemix-adjusted payment amount by 3.35% to reflect inflation between RY92 and RY93; by 3.01% to reflect inflation between RY93 and RY94; by 2.80% to reflect inflation between RY94 and RY95; and by 3.16% to reflect inflation between RY95 and RY96.

There will also be outlier payments for patients whose length of stay during a single hospitalization exceeds twenty acute days. For any pediatric hospital (as defined in Section 2) which had a minimum of 2,500 pediatric admissions in rate year 1994, the Division will reimburse outlier days at the hospital's transfer per diem rate.

Acute hospitals which receive payment as specialty hospitals and pediatric units shall be determined by the Division.

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3. Public Service Hospital Providers

The standard inpatient payment amount per discharge for public service hospital providers (as defined in Section II) shall be equal to the sum of:

97% of the hospital's estimated actual FY90 cost per discharge, adjusted for casemix and inflation; and the hospital-specific pass-through amounts per discharge, direct medical education amount per discharge and the capital amount per discharge.

Derivation of estimated actual FY90 Medicaid costs is described in Section IV.A.2.

Adjustments were made for casemix by dividing the FY90 cost per discharge by the hospital's FY90 casemix index and then multiplying the result by the hospital's casemix index.

Adjustments were made for inflation by multiplying the casemix-adjusted payment amount by 3.35% to reflect inflation between RY92 and RY93; by 3.01% to reflect inflation between RY93 and RY94; by 2.80% to reflect inflation between RY94 and RY95; and by 3.16% to reflect inflation between RY95 and RY96.

There will also be outlier payments for patients whose length of stay during a single hospitalization exceeds twenty acute days.

Acute hospitals which receive payment as public service hospital providers shall be determined by the Division.

4. Essential Neonatal Intensive Care Unit (NICU) Services

Hospitals with DPH designated inpatient neonatal intensive care units qualify for the payment amounts described below.

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a. Supplementary Essential NICU Services

Payment for essential NICU services, for hospitals that began operating and admitting NICU patients during rate year 1993, shall be made as an add-on to the hospital-specific SPAD rate described in Section IV.A.2. The add-on amount shall equal the Medicaid share of reasonable costs of the NICU unit (as submitted to and approved by the Division) divided by projected and approved FY93 total Medicaid discharges. The Medicaid share of NICU costs shall equal reasonable per discharge costs of the NICU unit multiplied by projected FY93 Medicaid NICU discharges. The hospital-specific NICU add-on was updated for inflation using factors of 3.01% to reflect price changes from RY93 to RY94, 2.80% to reflect price changes from RY94 to RY95 and 3.16% to reflect price changes from RY95 to RY96.

b. Existing Essential NICU Services

Payment for capital costs associated with existing essential NICU services, where these capital costs were recognized in the FY92 RFA reimbursement methodology, shall be made as an add-on to the capital payment amount per discharge described in Section IV.A.5. The add-on amount shall equal: FY92 capital costs related to the NICU unit, divided by the hospital's total FY91 non-DPU days, and then multiplied by the hospital-specific non-DPU FY91 Medicaid average length of stay (see Section IV.A.5). The hospital-specific NICU add-on amount was updated for inflation using factors of 3.01% to reflect price changes from RY93 to RY94, 2.80% to reflect price changes from RY94 to RY95 and 3.16% to reflect price changes from RY95 to RY96.

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**C. Classification of Disproportionate Share Hospitals (DSHs) and Payment Adjustments**

Medicaid will assist hospitals that carry a disproportionate financial burden of caring for uninsured and publicly insured persons of the Commonwealth. In accordance with Title XIX rules and requirements, Medicaid will make an additional payment adjustment above the rate under the RFA contract to hospitals which qualify for such an adjustment under any one or more of the classifications listed below. Only hospitals that have an executed contract with the Division, pursuant to the RFA, are eligible for disproportionate share payments since the dollars are, in most cases, apportioned to the eligible group in relation to each other. Medicaid-participating hospitals may qualify for adjustments and may receive them at any time throughout the rate year. If a hospital's RFA contract is terminated, its adjustment shall be prorated for the portion of the rate year during which it had a contract with the Division. The remaining funds it would have received shall be apportioned to remaining eligible hospitals. The following describes how hospitals will qualify for each type of disproportionate share adjustment and the methodology for calculating those adjustments.

The Division has added the following requirements to be eligible for DSH payments, in accordance with recent changes to federal and state law. First, hospitals must have a Medicaid inpatient utilization rate of at least 1% to be eligible for any type of DSH payment, pursuant to recently amended regulations promulgated by the Rate Setting Commission and found at 114.1 CMR 36.13(10) (attached as **Exhibit 5**). Second, the total amount of DSH payment adjustments awarded to any hospital shall not exceed the costs incurred during the year of furnishing hospital services to individuals who are either eligible for medical assistance or have no health insurance or other source of third party coverage less payments received by the hospital for medical assistance and by uninsured patients ("unreimbursed costs").

When a hospital applies to participate in Medicaid, its eligibility and the amount of its adjustment shall be determined. As new hospitals apply to become Medicaid providers, they may qualify for adjustments if they meet the criteria under one or more of the following DSH classifications. Therefore, some disproportionate share adjustments may require recalculation pursuant to Rate Setting Commission regulations set forth at 114.1 CMR 36.13(10). Hospitals will be informed if the adjustment amount will change due to reapportionment among the qualified group and will be told how overpayments or underpayments by the Division will be handled at that time.

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To qualify for a DSH payment adjustment under any classification within Section III.C, a hospital must meet the obstetrical staffing requirements described in Title XIX at 42 U.S.C. §1396r-4(d) or qualify for the exemption described at 42 U.S.C. §1396r-4(d) (2).

**1. High Public Payor Hospitals: Sixty-Three Percent Hospitals  
(Total Funding: \$11,700,000)**

The eligibility criteria and payment formula for this DSH classification are specified in regulations of the Rate Setting Commission at 114.1 CMR 36.13(10)(a) (attached as **Exhibit 5**). For purposes of this classification only, the term "disproportionate share hospital" refers to any acute hospital that exhibits a payor mix where a minimum of sixty-three percent of the acute hospital's gross patient service revenue is attributable to Title XVIII and Title XIX of the Federal Social Security Act, other government payors and free care.

**2. Basic Federally Mandated Disproportionate Share Adjustment  
(Total Funding: \$200,000)**

The eligibility criteria and payment formula for this DSH classification are described in regulations of the Rate Setting Commission at 114.1 CMR 36.13(10)(b) (attached as **Exhibit 5**) and in accordance with the minimum requirements of 42 U.S.C. §1396r-4.

**3. Disproportionate Share Adjustment for Safety Net Providers**

A disproportionate share safety net adjustment factor for all eligible hospitals shall be determined.

This class of hospital was identified and included to ensure that those hospitals that provide the services most critical to the poor are reimbursed for their overload of free care so that they can continue to provide the services that we deem crucial to the provision of adequate health care.

**a. Determination of Eligibility**

The disproportionate share adjustment for safety net providers is an additional payment for all hospitals eligible for the basic federally-mandated disproportionate share adjustment pursuant to Section IV.2.C.2. above, which also meet the following additional criteria:

- i. is a public hospital;
- ii. has a volume of free care charges in FY93 that is at least 15% of total charges;
- iii. is an essential safety net provider in its service area, as demonstrated by delivery of services to populations with special needs, including persons with AIDS, trauma victims, high-risk neonates, and

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indigent patients without access to other providers;

- iv. has completed an agreement with the Division of Medical Assistance for the federally-mandated disproportionate share adjustment for safety net providers.

b. **Payment Methodology**

An additional adjustment shall be calculated for federally-mandated disproportionate share hospitals that are eligible for the safety net provider adjustment.

- i. This payment amount shall be reasonably related to the costs of services provided to patients eligible for medical assistance under Title XIX, or to low-income patients.
- ii. This payment adjustment shall be based on an agreement between the Division and the qualifying hospital. The Division shall make a disproportionate share payment adjustment to the qualifying hospital; provided that such payment shall be adjusted if necessary, to ensure that a qualifying hospital's total disproportionate share adjustment payments for a fiscal year under the State Plan do not exceed 100% of such hospital's total unreimbursed free care and unreimbursed Medicaid costs for the same fiscal year. Such unreimbursed costs shall be calculated by the Division using the best data available, as determined by the Division for the fiscal year.
- iii. The payment of the safety net adjustment to a qualifying hospital in any rate year shall be contingent upon the continued availability of federal financing participation for such payments.

4. **Uncompensated Care Disproportionate Share Adjustment**

Hospitals eligible for this adjustment are those acute facilities that incur "free care costs" as defined in regulations of the Department of Medical Security (DMS) at 117 CMR 7.00 (attached as Exhibit 6). The payment amounts for eligible hospitals participating in the free care pool are determined and paid by the

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Department of Medical Security in accordance with its  
regulations at 117 CMR 7.00.

D. Treatment of Reimbursement for Recipients in the Hospital on  
the Effective Date of the Hospital Contract

Except where payments are made on a per diem basis,  
reimbursement to participating hospitals for services  
provided to Medicaid recipients who are at acute inpatient  
status prior to October 1, 1995 and who remain at acute  
inpatient status on October 1, 1995 shall continue to be at  
the hospital's rates established prior to the RY96 RFA.

E. Upper Limit

Payment adjustments may be made for reasons relating to the  
Upper Limit if the number of hospitals that apply and qualify  
changes, if updated information necessitates a change, or as  
otherwise required by the Health Care Financing  
Administration (HCFA).

F. Future Rate Years

Adjustments may be made each rate year to update rates.

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G. Errors in Calculation of Pass-through Amounts, Direct Medical Education Cost or Capital Costs

If a transcription error occurred or if the incorrect line was transcribed in the calculation of pass-through costs, direct medical education costs or capital costs, resulting in an amount not consistent with the methodology, a correction can be made at any time during the term of the contract upon agreement by both parties. Such corrections will be made to the final hospital-specific rate retroactive to the effective date of the contract resulting from the RFA but will not affect computation of the statewide average payment amount or of any of the efficiency standards applied to inpatient costs, or to capital costs. Hospitals must submit copies of the relevant report as referenced in Data Sources (Section IV.1), highlighting items found to be in error, to Kiki Feldmar, Division of Medical Assistance, Benefit Services, 5th floor, 600 Washington Street, Boston, MA 02111 during the term of the contract to initiate a correction.

H. Hospital Mergers

Hospitals that have merged after October 1, 1990 and have applied for and received a single inpatient Medicare provider number, a single inpatient Medicaid provider number, and single outpatient Medicaid provider number (excluding hospital-licensed health centers) shall be assigned a single combined weighted average for each of the following: SPAD, transfer, outlier, chronic, and psychiatric per diem rates, and cost-to-charge ratio. The weights shall equal each hospital's FY90 Medicaid discharges as a proportion of total Medicaid discharges for the merged hospitals, and shall be applied to the RY96 RFA inpatient rates which were calculated for each hospital. The administrative day per diem rate shall not be recalculated.

I. New Hospitals

The rates of reimbursement for a newly participating hospital shall be determined in accordance with the provisions of the RFA to the extent the Division deems possible. If data sources specified by the RFA are not available, or if other factors do not permit precise conformity with the provisions

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*of the RFA, the Division shall select such substitute data sources or other methodology(ies) which the Division deems appropriate in determining the hospital's rates. Such rates shall not affect computation of the statewide average payment amount or any of the efficiency standards applied to inpatient costs or to capital costs.*

**TN 95-17  
Supersedes TN 94-20,  
TN 95-01, TN 95-10**

**Approval Date** JUN 06 1995  
**Effective Date** 10/1/95

**INSTITUTIONAL STATE PLAN  
ASSURANCE AND FINDING CERTIFICATION STATEMENT**

STATE: Massachusetts  
TN: 95-17

REIMBURSEMENT TYPE:   Inpatient hospital         x    
                          Nursing facility               
                          ICF/MR                     

PROPOSED EFFECTIVE DATE: October 1, 1995

A. State Assurances and Findings. The State assures that it has made the following findings:

1. 447.253(b)(1)(i) - The State pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable state and Federal laws, regulations, and quality and safety standards.           x

2. With respect to inpatient hospital services --

- a. 447.253(b)(1)(ii)(A) - The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs.           x

- b. 447.253(b)(1)(ii)(B) - If a State elects in its State plan to cover inappropriate level of care services (that is, services furnished to hospital inpatients who require a lower covered level of care such as skilled nursing services or intermediate care services, under conditions similar to those described in section 1861(v)(1)(G) of the Act, the methods and standards used to determine payment rates must specify that the payments for this type of care must be made at rates lower than those for inpatient hospital level of care services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act.           x

If the answer is "not applicable," please indicate:

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- c. 447.253(b)(1)(ii)(C) - The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.           x

3. With respect to nursing facility services --

- a. 447.253(b)(1)(iii)(A) - Except for preadmission screening for individuals with mental illness and mental retardation under 42 CFR 483.20(f), the methods and standards used to determine payment rates take into account the costs of complying with the requirements of 42 CFR part 483 subpart B.           n/a

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- b. 447.253(b)(1)(iii)(B) - The methods and standards used to determine payment rates provide for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care under a waiver of the requirement in 42 CFR 483.30(c) to provide licensed nurses on a 24-hour basis. n/a
- c. 447.253(b)(1)(iii)(C) - The State has established procedures under which the data and methodology used to establish payment rates are made available to the public. n/a
4. 447.253(b)(2) - The proposed payment rate will not exceed the upper payment limits as specified in 42 CFR 447.272:
- a. 447.272(a) - Aggregate payments to each group of health care facilities (hospitals, nursing facilities, and ICFs/MR) will not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. x
- b. 447.272(b) - Aggregate payments to each group of State-operated facilities (that is, hospitals, nursing facilities, and ICFs/MR) -- when considered separately -- will not exceed the amount that can reasonably be estimated would have been paid for under Medicare payment principles. x
- If there are no State-operated facilities, please indicate "not applicable:" \_\_\_\_\_
- c. 447.272(c) - Aggregate disproportionate share hospital (DSH) payments do not exceed the DSH payment limits at 42 CFR 447.296 through 447.299. x
- d. Section 1923(g) - DSH payments to individual providers will not exceed the hospital-specific DSH limits in section 1923(g) of the Act. x
- B. State Assurances. The State makes the following additional assurances:
1. For hospitals --
- a. 447.253(c) - In determining payment when there has been a sale or transfer of the assets of a hospital, the State's methods and standards provide that payment rates can reasonably be expected not to increase in the aggregate solely as a result of changes of ownership, more than payments would increase under Medicare under 42 CFR 413.130, 413.134, 413.153 and 413.157 insofar as these sections affect payment for depreciation, interest on capital indebtedness, return on equity (if applicable, acquisition costs for which payments were previously made to prior owners, and the recapture of depreciation. x

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2. For nursing facilities and ICFs/MR--

- a. 447.253(d)(1) - When there has been a sale or transfer of the assets of a NF or ICF/MR on or after July 18, 1984 but before October 1, 1985, the State's methods and standards provide that payment rates can reasonably be expected not to increase in the aggregate, solely as a result of a change in ownership, more than payments would increase under Medicare under 42 CFR 413.130, 413.134, 413.153 and 413.157 insofar as these sections affect payment for depreciation, interest on capital indebtedness, return on equity (if applicable), acquisition costs for which payments were previously made to prior owners, and the recapture of depreciation. n/a
- b. 447.253(d)(2) - When there has been a sale or transfer of the assets of a NF or ICF/MR on or after October 1, 1985, the State's methods and standards provide that the valuation of capital assets for purposes of determining payment rates will not increase (as measured from the date of acquisition by the seller to the date of the change of ownership) solely as a result of a change of ownership, by more than the lesser of:
- (i) 1/2 of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Dodge construction index applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year; or
- (ii) 1/2 of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Consumer Price Index for All Urban Consumers (CPI-U) (United States city average) applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year. n/a
3. 447.253(e) - The State provides for an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the State determines appropriate, of payment rates. x
4. 447.253(f) - The State requires the filing of uniform cost reports by each participating provider. x
5. 447.253(g) - The State provides for periodic audits of the financial and statistical records of participating providers. x

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6. 447.253(h) - The State has complied with the public notice requirements of 42 CFR 447.205.

Notice published on: August 11, 1995<sup>2</sup>

If no date is shown, please explain: \_\_\_\_\_

7. 447.253(i) - The State pays for inpatient hospital and long-term care services using rates determined in accordance with the methods and standards specified in the approved State plan. x

C. Related Information

1. 447.255(a) - NOTE: If this plan amendment affects more than one type of provider (e.g., hospital, NF, and ICF/MR; or DSH payments) provide the following rate information for each provider type, or the DSH payments. You may attach supplemental pages as necessary.

Provider Type: Inpatient Acute Hospital

For hospitals: Include DSH payments in the estimated average rates. You may either combine hospital and DSH payments or show DSH separately. If including DSH payments in a combined rate, please initial that DSH payment are included. DSH payments not included

Estimated average proposed payment rate as a result of this amendment: see attached

Average payment rate in effect for the immediately preceding rate period: see attached

Amount of change: see attached

Percentage of change: see attached

2. 447.255(b) - Provide an estimate of the short-term and, to the extent feasible, long-term effect the change in the estimated average rate will have on:

(a) The availability of services on a statewide and geographic area basis: no effect

(b) The type of care furnished: no effect

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<sup>2</sup>Minor clarifications and corrections which do not affect the inpatient acute hospital payment methodology were made subsequent to publication of this public notice. They involve the definition of a hospital-based physician, a technical correction to the statewide average payment amount, and a clarification regarding the wage area index. The notices addressing these clarifications are not included due to their non-substantive nature.

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- (d) For hospitals -- the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs: no effect

I HEREBY CERTIFY that to the best of my knowledge and belief, the information provided is true, correct, and a complete statement prepared in accordance with applicable instructions.

Completed by Lisa McDonough Date 12/29/95  
Title: Senior Reimbursement Analyst  
Division of Medical Assistance

## Related Rate Attachment to Assurance and Finding Certification Statement

In accordance with 42 CFR 447.255, the Medicaid agency provides the following information on FY96 estimated average rates and the amount by which these have changed before and after the effective date of the State Plan Amendment.

<u>Period</u>	<u>Estimate Acute Per Diem</u>	<u>Projected Annual Disproportionate Share Hospital Payments</u>
4/8/95 – 9/30/95	925.67	\$387M*
10/1/95 – 9/30/96	979.15	\$412M
Difference:	5.78%	6.46%

\* Total RY95 DSH payments

In accordance with 42 CFR 447.255, the Medicaid agency estimates that the change in estimated average rates will have no negative short-term or long-term effect on the availability of services (both on a statewide and geographic basis); the type of care furnished; the extent of provider services and participation; and the degree to which costs are covered in disproportionate share hospitals.

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**TN 95-17**  
**STATE PLAN AMENDMENT**  
**INPATIENT ACUTE HOSPITAL**

**EXHIBIT 1: 130 CMR 415.415, 130 CMR 415.416**

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415.414: continued

(C) If, as the result of a concurrent review, the Division or its agent determines that a recipient's stay is no longer administratively necessary due to the availability of an appropriate placement, the Division will not pay for any part of the hospital stay that follows ten days after the date of notice to the hospital and to the recipient that the stay is no longer administratively necessary.

(D) If, as the result of a review, the Division or its agent determines that there was no medical or administrative necessity for a hospital admission, a hospital stay, or any part of a hospital stay, the Division will not pay for that admission, stay, or part of a stay.

(E) If, as the result of a review, the Division or its agent denies the need for any hospital service delivered to a recipient during a hospital stay, the Division will not pay for that service.

(F) If a hospital stay or service is reviewed by the Division or its agent concurrently with a recipient's acute hospital admission or stay and the admission, service, and stay, or any part of it, are certified at the time of review as medically or administratively necessary and appropriate, the Division will treat that certification as binding for payment purposes.

(G) If, as the result of a review, the Division or its agent determines that any hospital admission, stay, or service provided to a recipient was subject to a service limitation (see 130 CMR 450.106) and was delivered without obtaining authorization from the recipient's primary-care provider, the Division will not pay for that admission, stay, or service.

(H) Certification of out-of-state hospital claims must be made by the organization responsible for that state's Medical Assistance Program utilization review.

#### 415.415: Reimbursable Administrative Days

(A) Administrative days as defined in 130 CMR 415.402 are reimbursable if the following conditions are met:

- (1) the recipient requires an admission to a hospital or a continued stay in a hospital for reasons other than the need for services that can only be provided in an acute inpatient hospital as defined in 130 CMR 415.402 (see 130 CMR 415.415(B) for examples); and
- (2) a hospital is making regular efforts to discharge the recipient to the appropriate setting. These efforts must be documented according to the procedures described in 130 CMR 450.205. The regulations covering discharge-planning standards described in 130 CMR 415.419 must be followed, but they do not preclude additional, effective discharge-planning activities.

(B) Examples of situations that may require hospital stays at less than a hospital level of care include, but are not limited to, the following.

- (1) A recipient is awaiting transfer to a chronic disease hospital, rehabilitation hospital, nursing facility, or any other institutional placement.
- (2) A recipient is awaiting arrangement of home services (nursing, home health aide, durable medical equipment, personal care attendant, therapies, or other community-based services).
- (3) A recipient is awaiting arrangement of residential, social, psychiatric, or medical services by a public or private agency.
- (4) A recipient with lead poisoning is awaiting deleading of his or her residence.
- (5) A recipient is awaiting results of a report of abuse or neglect made to any public agency charged with the investigation of such reports.
- (6) recipient in the custody of the Department of Social Services is awaiting foster care when other temporary living arrangements are unavailable or inappropriate.

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415.415: continued

- (7) A recipient cannot be treated or maintained at home because the primary caregiver is absent due to medical or psychiatric crisis, and a substitute caregiver is not available.
- (8) A recipient is awaiting a discharge from the hospital and is receiving skilled nursing or other skilled services. Skilled services include, but are not limited to:
  - (a) maintenance of tube feedings;
  - (b) ventilator management;
  - (c) dressings, irrigations, packing, and other wound treatments;
  - (d) routine administration of medications;
  - (e) provision of therapies (respiratory, speech, physical, occupational, etc.);
  - (f) insertion, irrigation, and replacement of catheters; and
  - (g) intravenous, intramuscular, or subcutaneous injections, or intravenous feedings (for example, total parenteral nutrition.)

415.416: Nonreimbursable Administrative Days

Administrative days are not reimbursable when:

- (A) a hospitalized recipient is awaiting an appropriate placement or services that are currently available but the hospital has not transferred or discharged the recipient because of the hospital's administrative or operational delays;
- (B) the Division or its agent determines that appropriate noninstitutional or institutional placement or services are available within a reasonable distance of the recipient's noninstitutional (customary) residence and the recipient, the recipient's family, or any person legally responsible for the recipient refuses the placement or services; or
- (C) the Division or its agent determines that appropriate noninstitutional or institutional placement or services are available within a reasonable distance of the recipient's noninstitutional (customary) residence and advises the hospital of the determination, and the hospital or the physician refuses or neglects to discharge the recipient.

415.417: Notification of Denial, Reconsideration, and Appeals

- (A) Notification of Denial. The Division or its agent shall notify the recipient, the hospital, and the recipient's attending physician whenever it determines as part of a concurrent review that the hospital admission or stay, or any part thereof, is not medically or administratively necessary. The Division or its agent shall notify the hospital and the recipient's attending physician whenever it determines as part of a concurrent or retrospective review that the hospital stay is or was no longer medically necessary but is or was administratively necessary. The Division or its agent shall notify the hospital and the recipient whenever it determines as part of a concurrent review that a hospital stay is no longer administratively necessary due to the refusal of an appropriate placement.
- (B) Reconsideration. An agent of the Division under 130 CMR 415.000 may provide an opportunity for reconsideration of a determination made by that agent. If a reconsideration is available, notice of the agent's determination will include written notice of: the right to a reconsideration; the time within and manner in which a reconsideration must be requested; and the time within which a decision will be rendered. A hospital, a physician, or a recipient entitled to have a determination reconsidered must request and have a reconsideration determination given before requesting a hearing under 130 CMR 415.417(C).
- (C) Appeals to the Division.
  - (1) A recipient may request a fair hearing before the Division when the Division or its agent determines as the result of a concurrent review that a continued stay is not administratively necessary due to the availability of an appropriate placement as described in 130 CMR 415.415.

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**TN 95-17**  
**STATE PLAN AMENDMENT**  
**INPATIENT ACUTE HOSPITAL**

**EXHIBIT 2: TRANSFER MATRICES**

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**TRANSFERRING RULES- WITHIN A HOSPITAL**  
**MANAGED CARE RECIPIENT**

**NON-MANAGED CARE RECIPIENT**

TO: RECEIVING UNIT				
FROM : TRANSFERRING UNIT		MED SURG	** PSYCH	SUB\ABUSE
MH\SA NETWORK HOSPITAL	MED\SURG	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: MH\SA CONTRACT RATE	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: MH\SA CONTRACT RATE
	** PSYCHIATRIC	TRANSFERRING UNIT: MH\SA CONTRACT RATE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: MH\SA CONTRACT RATE	TRANSFERRING & RECEIVING UNITS: MH\SA CONTRACT RATE
	SUBSTANCE ABUSE	TRANSFERRING UNIT: MH\SA CONTRACT RATE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: MH\SA CONTRACT RATE	TRANSFERRING & RECEIVING UNITS: MH\SA CONTRACT RATE
NON-MH\SA NETWORK HOSPITAL	MED\SURG	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: NOT REIMBURSABLE	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: NOT REIMBURSABLE
	** PSYCHIATRIC	TRANSFERRING UNIT: NOT REIMBURSABLE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING * & RECEIVING UNITS: NOT REIMBURSABLE	TRANSFERRING * & RECEIVING UNITS: NOT REIMBURSABLE
	SUBSTANCE ABUSE	TRANSFERRING UNIT: NOT REIMBURSABLE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING * & RECEIVING UNITS: NOT REIMBURSABLE	TRANSFERRING * & RECEIVING UNITS: NOT REIMBURSABLE

		MED SURG	** PSYCH	SUB\ABUSE
	MED\SURG	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY
	** PSYCHIATRIC	TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: PSYCH PER DIEM	TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM
	SUBSTANCE ABUSE	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY
	MED\SURG	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY
	** PSYCHIATRIC	TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: PSYCH PER DIEM	TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM
	SUBSTANCE ABUSE	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANS PER DIEM RECEIVING UNIT: PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY

**OFFICIAL**

\* IN CASES OF AN EMERGENCY ADMISSION OF A MANAGED CARE RECIPIENT IN A NON-NETWORK HOSPITAL, THE HOSPITAL MUST FOLLOW AUTHORIZATION PROCEDURES OUTLINED IN 106 CMR 450.125, AND SHALL BE REIMBURSED BY THE DIVISION'S MH\SA PROVIDER AT THE CURRENT ACUTE HOSPITAL RFA RATE FOR PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES.

\*\* IN CASES INVOLVING A TRANSFER TO OR FROM A DMH REPLACEMENT UNIT, SUBSTITUTE THE DMH CONTRACT RATE IN THE ABOVE MATRIX WHERE APPROPRIATE. A DMH RATE CAN APPLY IN CIRCUMSTANCES WHERE THE MATRIX INDICATES THE SERVICE IS NOT REIMBURSABLE. ALL OTHER RULES RELATED TO TRANSFERS WITHIN A HOSPITAL SHALL APPLY.